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Good morning, Chairman Henneberry and Commission members. Thank you for allowing me the opportunity to speak with you this morning and to share some insights from a study of state pharmacy assistance programs that my colleagues and I have conducted over the past three years that I hope will be helpful to the Commission in fulfilling its charge.

My name is Kimberley Fox and I am a Senior Policy Analyst at the Rutgers Center for State Health Policy (CSHP). With support from The Commonwealth Fund, and under the leadership of my colleague Stephen Crystal, CSHP has undertaken a study of state pharmacy assistance programs to assess best practices and lessons that might be learned to inform the design and implementation of a Medicare prescription drug benefit. As part of this study, we have conducted three annual surveys of SPAPs, case studies of eight state subsidy programs and six discount card programs, and most recently telephone interviews with SPAP program directors on their plans to coordinate with the new Medicare drug benefit. We have already issued a number of reports, links to which I have made available to the Commission's staff. We are also soon to release two reports including a chartbook that includes detailed information on SPAP benefit structure, eligibility requirements, enrollment, utilization, and costs and a report on coordination of benefit issues, both of which we believe are very relevant to your work and that we will share with the Commission as soon as they are available. This testimony draws from the findings of this work.

To assist the Commission in its charge to ensure a smooth and seamless transition for SPAP enrollees into the new Medicare drug benefit my testimony will focus on:

1) Generally describing how SPAPs compare and contrast with the Medicare benefit;
2) Discussing different options for wrapping around the Part D Medicare benefit that states are considering and anticipated challenges;
3) Describing existing third party payment collection by SPAPs and current efforts to coordinate with the temporary $600 transitional assistance available under the

interim Medicare-endorsed discount cards; and some of the key lessons learned for coordinating with the new Medicare Part D drug benefit going forward.

1) How SPAP benefits compare with Medicare?

In 2003, twenty two states offered more than 1.5 million enrollees subsidies for prescription drugs. The designs of these programs vary considerably across states. While most of these programs are funded solely by state dollars, six states (FL, IL, MD, SC, WI, VT) obtained Medicaid waivers to extend Medicaid drug coverage to low-income seniors and/or disabled who are not Medicaid eligible. Since Medicaid and Medicaid-waiver programs are treated separately in the MMA and the future of these waiver programs is still unknown, this testimony focuses on the remaining 17 states that have SPAPs supported solely by state funds that serve approximately 1.1 million enrollees[1].

With average income eligibility limits of 220% FPL, the principal challenge for SPAPs will be addressing prescription drug affordability for the near-poor and those with some assets, who are eligible only for the basic Part D benefit which is typically less generous than SPAP benefits. While benefit designs vary considerably across state programs (see Table 1), for SPAP enrollees with incomes above 150% FPL who represent as many as half the enrollees in some state programs, basic Part D coverage requires greater cost-sharing than the benefit in many SPAPs, particularly for those enrollees who spend less than $5,100 per year on drugs. In contrast, for those who have incomes under 150% of poverty and few assets, low-income Part D subsidies generally provide cost-sharing equivalent to or better than that provided by SPAPs, but may restrict access to some drugs through PDP formularies or preferred drug lists.

Estimating low-income subsidy eligibility is a challenge for SPAPs. To develop a coordination plan with Medicare, all states will need to estimate how many of their enrollees are eligible for the standard Part D benefit, and how many are eligible for the two tiers of low-income subsidies, as each benefit level will require different wrap-around requirements by the state. As only two SPAPs currently require an asset test as a condition of program eligibility (MN and MD), the remaining states either need to collect this information from their current enrollees, which would be a difficult task, or use proxy measures to estimate the number of persons eligible for each Medicare benefit category. For example, New Jersey has used the proxy measure of interest and dividend income reported on its program applications. By this measure, NJ estimated that approximately 22% of income eligible persons in the lowest income tier (<135% FPL) and 14% of income eligible persons in the low-income tier (135-150% FPL) may not meet the asset test. Other states that do not collect similar information on their applications have used more general estimates. For example, in assessing the potential savings to the state from the new Medicare benefit and remaining gaps in coverage, Missouri assumed that 10% of income-eligible persons would not meet the Medicare asset test.

[1] Our analysis includes Illinois, which has both a Medicaid waiver and a state-only program that serves disabled persons under 135% FPL who are eligible for transitional assistance.

Medicare Drug Formularies Likely to be More Limited than SPAPs
In addition to differences in eligibility and cost-sharing, the Medicare benefit also may cover fewer drugs than are currently available through SPAPs. The Medicare drug benefit will be administered by multiple private companies that will utilize cost containment methods that most SPAPs are not currently using. For example, while Prescription Drug Plans are required to cover drugs in each of the drug categories and classes that are not explicitly excluded from Medicare drug coverage, they are allowed to use closed or restricted formularies that may limit coverage to only two drugs per class, or have higher cost-sharing for non-preferred off-formulary drugs. With the exception of a few states that limit drugs covered to certain conditions (ME, IL, NC, MD), state pharmacy assistance programs generally have open formularies, meaning that enrollees have access to most drugs that have been FDA-approved for which the state has been able to obtain a manufacturer rebate. Thus, depending on the formulary of the specific plan selected, SPAP enrollees may no longer have access to certain drugs that are currently covered under their state program[2]. Particularly in some drug classes, such as psychiatric drugs, there is some research evidence that many patients and their physicians are hesitant to switch medications in response to formulary changes, even if the out-of-pocket impact is significant. This might lead even individuals eligible for subsidized Part D benefits to seek help from states. The issue of help with access to off-formulary drugs may become a complex one for states, given the disallowance of spending for off-formulary drugs in the calculation of "true out-of-pocket costs."

More Limited Pharmacy Networks
Similarly, PDPs may have more limited pharmacy networks than SPAPs. While the Medicare benefit has minimum geographical standards for pharmacy coverage that the PDPs must meet, it is unlikely that the PDPs in a region will have the same pharmacy coverage that is available in most SPAPs, which generally average anywhere from 95-100% of pharmacies in the state. In fact, states have reported that many of the discount cards, which must comply with similar minimum pharmacy network requirements as those required under Part D, do not have as extensive networks as the SPAP.

2) Do States Plan to Continue Coverage and If So, How?

Most SPAPs plan to continue some low-income drug coverage in 2006. Based on interviews in May/June 2004, only two states (Kansas and Wyoming[3]) of those contacted had definitive plans to stop providing prescription drug coverage for Medicare beneficiaries in 2006. Minnesota, Indiana, and North Carolina, which target very low-income seniors who will receive the greatest benefit from the new Medicare prescription drug law, were uncertain of their future status in 2006. However, the vast majority of states had plans to continue to provide supplemental coverage in some form.

[2] Note that four states (NC, IL, ME, MD) currently restrict drug coverage to certain conditions and thus enrollees in these states will have access to a larger number of drugs.
[3] As Wyoming's program does not limit eligibility by age, it will continue its SPAP for non-elderly, non-Medicare beneficiaries.

Most States Still Considering Part D COB Options; Focused on Implementing Discount Card

The MMA requires Part D prescription drug plans to coordinate benefits with SPAPs that provide financial assistance for the purchase or provision of supplemental prescription drug coverage or benefits on behalf of part D eligible individuals and which offer the same benefit regardless of the part D plan in which the individual is enrolled. States can either opt to coordinate benefits with the private PDPs available in their region or pay a Prescription Drug Plan a lump sum for the private plan to provide supplemental coverage on the state's behalf. The law also allows for the use of a single card that a part D plan may issue in connection with coverage of benefits provided by a SPAP.

With one exception, states were still in the preliminary stages of defining how they would wrap-around the Medicare benefit. Since the full Medicare Part D benefit will not be available until 2006, states have focused most of their attention to date on coordinating with the interim Medicare-endorsed discount card program, which began in June of 2004. However some options being considered for Part D include paying all or a portion of the Part D premiums, wrapping around cost-sharing to the current state coverage, or providing coverage for beneficiaries affected by the "doughnut hole," all of which will require detailed, real-time information-sharing between PDPs and states to work effectively. At the time of our interviews, few states had considered the lump sum payment option, primarily due to the difficulty of developing an actuarial model for determining an appropriate level of payment.

Missouri Takes the Lead in Proposing a Doughnut Hole Plan

State pharmacy assistance programs are unique compared to other insurers or Medicaid in that the MMA explicitly allows the dollars that SPAPs contribute toward on-formulary drugs during the deductible period, and towards cost-sharing both before and during the 'doughnut hole' period to be counted as true out-of-pocket costs for the consumer. Thus, SPAPs can help consumers with high drug costs reach the generous Medicare catastrophic benefit without having to expend $3600 on their own. The governor of Missouri has already decided to take advantage of this unique opportunity by proposing to restructure its current benefit plan in 2006 to be a 'doughnut hole' supplemental plan for Medicare low-income beneficiaries up to 200% FPL who do not qualify for low-income subsidies in 2006. It is the first state in the country to propose legislation to explicitly use state pharmacy dollars for this purpose. While the proposal did not pass in this legislative session, program officials indicated that the state will revisit the proposal in the next session once the Medicare regulations are released.

3) What Can Be Learned from Existing COB Efforts with Other Third Party Payers and with the new Medicare Discount Cards?

In the discount card program, auto-enrollment of SPAP beneficiaries into one preferred card sponsor appears to be a highly successful strategy for enrolling eligible individuals. Based on aggregation of estimates from program officials in 15 states, approximately 540,000 SPAP enrollees, about half of total current enrollment, are eligible for the $600 transitional assistance credit on the Medicare-endorsed discount cards (see TABLE 2). Three states (CT, ME, WY) have mandated enrollment in Medicare discount cards to ensure enrollment. The majority of other states were facilitating enrollment by working with a preferred card and/or autoenrolling their members (see Table 3). Some have also provided incentives to their members to enroll (see Table 4). Approximately 435,800 (80%) of SPAP TA-eligibles are already or are in the process of being autoenrolled. SPAPs that automatically enrolled their TA-eligible members into a preferred discount card found this strategy to be very effective and relatively transparent to enrollees and recommend that a similar strategy be pursued for Part D. The Commission may want to consider ways in which this approach could be implemented in Part D.

Claims coordination in the discount card program requires duplicate billing on the part of pharmacies, using third party liability fields. While transitional assistance is available, most SPAPs are either completely blocking payment until the $600 is spent down or are paying all or some portion of the 5-10% coinsurance. In both cases, SPAPs are using their point-of-sale systems by flagging pharmacists of other coverage. Once flagged, the pharmacist is responsible for billing the other payer (i.e., the Medicare endorsed discount card) first, and in states which are wrapping around the coinsurance, entering the copayment amount required by the consumer in the third party liability (TPL) field. This model relies heavily on pharmacists to coordinate the benefits, and requires them to bill twice, requiring them to pay two separate transaction fees. If Part D is implemented in such a way as to require a similar procedure, this may become quite burdensome to pharmacies as well as adding significant additional administrative costs to the system.

Continued success in coordinating the $600 credit with SPAP benefits is reliant in large part on yet untested timely data-sharing with the preferred card sponsor as well as data file matches with CMS indicating what SPAP enrollees are enrolled, in what plans, and how much of the credit they have spent. This enrollment information, which has yet to be transmitted to states, is expected to be particularly critical for states that are not working with one preferred card, but also important for other states that intend to wrap around the benefit for all enrollees, whether they enroll in the preferred drug card, are enrolled in an exclusive Medicare HMO card, or opt-out and enroll in another card. Many SPAPs indicated that for Part D, where benefit designs will be even more complicated, information-sharing should be centralized as much as possible both by allowing states to work with a preferred PDP and by providing information directly to the states from CMS.

Coordinating payment from other third party payers where the state is deemed the payer of last resort, has required persistent efforts to gather information from insurers,

and has produced marginal return on investment. While many SPAP programs exclude persons with any other drug coverage from eligibility, seven states allow people to enroll in their programs either after their coverage has been exhausted or if that coverage is of lesser value than the benefit offered by the state. As the payer of last resort, some of these states have attempted to recover costs from the primary drug insurer. Other states have simply not elected to pursue payment from third parties to which they are entitled because states had insufficient data on the availability of other drug coverage for their enrollees and assumed that most of their enrollees did not have access to other coverage, which will not be the case in 2006. Those that have pursued third parties have found that even with strict state statutes requiring insurers and health plans to provide enrollment and benefit information, this has not been easy to enforce and has resulted in relatively minimal recoveries. As with the state Medicaid programs, SPAPs have generally needed to purchase the services of information brokers to gather information from multiple sources at an additional cost to the state.

Policy Implications for the SPAP Transition Commission's Work

Whatever the form that SPAP programs end up taking, coordinating their benefits with Part D will not be easy. It will require a significant amount of information exchange that is unlikely to go smoothly in even the best situation and even less likely to go smoothly with a large number of plans. While the number of PDP and MA-PD plans that will be available is still unknown, based on the experience of the discount card program there could be dozens of competing plans available. The administrative hassle required to coordinate benefits is likely to factor into states' decisions about how to move forward, and should be minimized as much as possible in order to encourage states to supplement the gaps in Medicare prescription drug coverage and provide the greatest coverage to Medicare beneficiaries, and to minimize crowd-out of the current state contributions to pharmacy assistance for the elderly and disabled

To minimize the burden of coordination, centralization of information-sharing appears to be the key, both through allowing states to work with a preferred PDP and through providing information directly to the states from CMS rather than from multiple plans. CMS is likely to be collecting all of the information required of SPAPs, in order for Medicare to calculate payments.

Based on the early experience coordinating with the discount cards, autoenrollment is the most efficient mode of getting people enrolled in Part D plans. However, the coordination with the discount cards is only in the early stages of implementation and many issues may still arise. For example, the success of the coordination-of-benefits model employed by states during the discount card period is tied to the degree to which pharmacies cooperate by duplicate billing. Based on previous experience with third party billing in some states, states may encounter more pharmacy resistance and may need to significantly increase both audits and interventions to ensure compliance. Continued tracking of the TA autoenrollment experience is needed to refine the process for Part D, particularly related to processing eligibility in a timely fashion, dealing with denials and resubmitting appeals, tracking disenrollment rates, and monitoring spend-down. As of June 18th, autoenrollment of SPAP TA eligibles had only taken place for enrollees in New Jersey and Pennsylvania.

The remaining states are still in various stages of submitting their autoenrollment files or awaiting CMS approvals. Tracking states' experience with the discount cards will be critical to assessing how different approaches taken by states have yielded intended results.

This concludes my testimony. I am happy to take any questions from the Commission and offer our services in the months ahead in assisting the Commission with its work. Thank you again for giving me the opportunity to speak with you.